Exhibit O
Brookwood Medical Center Records dated 3/5/04

PATIENT: BARRON, TOMMY D
PHYSICIAN: DAVID M. OSTROWSKI, MD
ADMITTED: 03/05/2004
PROCEDURE DATE: 03/05/2004

ACCT #: 20366050
MR #: 1006808
ROOM #:

PREOPERATIVE DIAGNOSIS: Severe fracture dislocation of the proximal end of the proximal phalanx of the right long finger.

POSTOPERATIVE DIAGNOSIS: Severe fracture dislocation of the proximal end of the proximal phalanx of the right long finger.

OPERATION: PIP level amputation, right long finger.

SURGEON: DAVID M. OSTROWSKI, MD

ASSISTANT AND/OR CO-SURGEON: STEVE PLUMMER

ANESTHESIA: General.

ESTIMATED BLOOD LOSS:

COMPLICATIONS:

INDICATIONS: This is a gentleman who sustained severe fracture dislocation of the PIP joint with highly comminuted displaced fracture of the proximal end of the proximal phalanx which was subacute. This hand and arm had previously been injured. The patient had a high level nerve injury with also muscle damage in the right forearm, as well as nerve damage. In addition to having this fracture, he had an insensate finger with abnormal muscle function. Because the patient has had poor function of his finger, could not come for regular therapy, was concerned about subsequent stiffness and deformity, he requested an amputation. After a very thorough discussion with the patient regarding the implications of this request and the permanency of the situation, and the fact that we could not guarantee him complete pain relief, he decided to proceed with amputation.

OPERATIVE PROCEDURE: With the patient on the operating table in the supine position and the anesthetic in effect, the right hand and arm were sterilely prepped and draped. Skin flaps were outlined on the finger. The limb was exsanguinated by wrapping with an Esmarch bandage and tourniquet inflated to 250 mmHg pressure. Incision was made dorsally and dissection carried down to subcutaneous tissue. Gentle spread dissection was carried out, crossing veins were protected. Superficial cutaneous nerve branches were dissected back proximal to the skin flap, cauterized and divided. The extensor tendon was transected within the flank, so it could be folded over the end of the proximal phalanx. Bone fragments consisting of the central slip attachment were debulked from the tendon. The volar skin flap was then incised and careful blunt and sharp dissection carried out. Flap was elevated off of flexor sheath. Nerves and arteries were transected and vessels cauterized. The skin flap was elevated proximally off the flexor sheath. The PIP joint was identified and flexor tendons were transected. Then by sharp dissection, the proximal phalanx was disarticulated. It was a severe fracture of the proximal phalanx with virtual destruction of the articular surface of the base of the proximal phalanx. The bone fragments were carefully removed. The collateral ligaments were excised. The condyles were resected with the sagittal saw, so as not to have a bulbous tip. The extensor tendon was laid over the distal end of the proximal phalanx and sutured to local soft tissue with interrupted 3-0 Vicryl. The digital nerves were cut proximal to the ultimate suture line, cauterized with bipolar cautery. Skin flaps were

then fashioned and trimmed and the skin edges coapted with interrupted 5-0 nylon suture. The finger was anesthetized at the metacarpal level with 1/4% plain Marcaine. A bulky soft dressing was applied. The tourniquet was released with brisk return of color to the hand. The patient tolerated the procedure well and was taken to the recovery room in good condition.

DAVID M. OSTROWSKI, MD

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